

1. PLACE OF DEATH
(a) County Chariton
(b) City or town Salisbury
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
In this community whole life (Specify whether years, months or days)

3. (a) PRINT FULL NAME John Overton Grisham
3. (b) If veteran, name war _____
3. (c) Social Security No. _____

4. Sex Male 5. Color or race W
6. (a) Single, widowed, married, divorced M
6. (b) Name of husband or wife Gadie Grisham
6. (c) Age of husband or wife if alive 68 years
7. Birth date of deceased Oct 20 1867
(Month) (Day) (Year)

8. AGE: Years 76 Months 5 Days 3
If less than one day. _____ hr. _____ min.

9. Birthplace Howard Co Mo
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business _____

12. Name Overton Grisham

13. Birthplace Unknown
(City, town, or county) (State or foreign country)

14. Maiden name Kate Jones

15. Birthplace Unknown
(City, town, or county) (State or foreign country)

16. (a) Informant Gadie Grisham

(b) Address Salisbury Mo

17. (a) Burial (b) Date thereof 3-26-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Salisbury

18. (a) Signature of funeral director Geo B. Winkler

(b) Address Salisbury Mo

19. (a) 4/20/44 (b) R. A. Kelly
(Data received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Chariton
(c) City or town Salisbury
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar, day 23
year 1944 hour 3 minute 30 P.M.

21. I hereby certify that I attended the deceased from Mar 10
1944, to 3-23 1944

that I last saw him alive on 3-23 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Chorea myoclonica

Due to _____

Due to Anemia Scleremii

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: 93d
Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) Means of injury _____

23. Signature Geo B. Winkler (M. D. or other) _____

Address Salisbury Mo Date signed 3/23/44

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

RECEIVED

District Health Officer No. 8,

District File Number

Date Filed

4-12-44

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by

working under my personal supervision.

Registered Apprentice No.

Signed

Chas. B. Wakeley

Licensed Embalmer No.

3842

P. O. Address

Salisbury

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.